

1960

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY OR (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Crisfield		1 hour		TOWN Crisfield		39	
HOSPITAL OR INSTITUTION OR STREET ADDRESS McCready Hospital				STREET ADDRESS (If rural give location) W. Main St. 1			
3. NAME OF DECEASED: (First) CHARLES (Middle) JACOB (Last) ABBOTT				4. DATE OF DEATH: (Month) February (Day) 8 (Year) 19 55			
5. SEX: male		5. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single		8. DATE OF BIRTH: June 16, 1954	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): none		10b. KIND OF BUSINESS OR INDUSTRY: none		9. AGE last birthday: 0 yrs. 7 Months 22 Days		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Guilford Abbott				14. MOTHER'S MAIDEN NAME: Jacqueline Sterling			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no 4		16. SOCIAL SECURITY No.: none		17. INFORMANT & ADDRESS: Guilford Abbott—W. Main St.—Crisfield, Md.			

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
571.0 Immediate cause					
(a) Gastro Enteritis Dehydrated					
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.					
(b) Cardiac Complication					
(c) Anemia					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
a Baby was dead before I was called.					
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR? No Accident	
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at 12:15 a.m. from the causes and on the date stated above.					
SIGNATURE		ADDRESS		DATE SIGNED	
W. H. Coulbourn M.D.		Crisfield, Md.		Feb 8-55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		Feb. 9, 1955		Crisfield Cemetery	
LOCATION (City, town, or county) (State)		DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
Crisfield, Md.		2-9-55		Bradshaw & Sons--Crisfield, Md.	
REGISTRAR'S SIGNATURE		ADDRESS			
Betty W. Tyler					

2004193384

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 15 1955
BUREAU V. S.

1961
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01948
Reg. Dist.

No. 261

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Shelltown</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Shelltown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u>		(Middle) <u>HANSON</u>		(Last) <u>CROPPER</u>		(Month) (Day) (Year) <u>February 7, 19 55</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Sept 15, 1887</u>	
						9. AGE last birthday: <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>farm owner</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Robert J. Cropper</u>				14. MOTHER'S MAIDEN NAME: <u>Virginia White</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Clive R. Cropper, Shelltown, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary Disease (Thrombosis)</u> DUE TO Antecedent cause(s) (b) <u>Arterio Sclerosis</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>W. H. Houlbourn</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Feb 7-55</u> DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rehoboth, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 9th, 1955</u>		REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>		24. FUNERAL DIRECTOR <u>Dennis & Watson, Pocomoke, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 16 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1801949
1962 CERTIFICATE OF DEATH

Reg. Dist. No. 262

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Somerset</u>	MARYLAND	STATE <u>Maryland</u>	<u>Somerset</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Pocomoke</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>		STREET ADDRESS (If rural give location) <u>R.F.D. 1</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>SALLIE ANN</u>	(Middle) <u>DENNIS</u>	(Last)	(Month) <u>Feb.</u> (Day) <u>6th</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>May 6, 1887</u>
9. AGE last birthday: <u>67</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Domestic Housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Walter Collins</u>		14. MOTHER'S MAIDEN NAME: <u>Alice Logan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>-</u>	
17. INFORMANT & ADDRESS: <u>Alice Crapper - Pocomoke, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
422.1 Immediate cause (a) <u>Cerebral Hemorrhage</u>		5 days	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arterio-sclerotic Cardio-Vascular Disease</u>		3 yrs	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1950</u> , 19... to <u>2/6</u> , 1955, that I last saw the deceased alive on <u>2/6</u> , 1955, and that death occurred at <u>10 AM</u> from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>Louis S. Llewellyn, M.D.</u>		ADDRESS <u>Pocomoke City, Md.</u> DATE SIGNED <u>2/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2-10-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. James</u>		LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/8/55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Ouelle Byrnes</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Edgar Wharton - New Church, Va.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

RECEIVED

FEB 14 1965

BUREAU V. S.

MARYLAND

1963

01950

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 260

Items 7/Film G177 2-16-55 et

1. PLACE OF DEATH COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Tolbert</u> (First) <u>Donohue</u> (Middle) <u>Donohue</u> (Last)		4. DATE OF DEATH <u>Feb. 5</u> , 19 <u>55</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 17, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no laborer on railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Widowed</u>	9. AGE last birthday <u>76 1/2</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11a. FATHER'S NAME <u>Julius Donohue</u>		11b. MOTHER'S MAIDEN NAME <u>Annie Christopher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>no.</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>no.</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Annie Barkley, Eden, Md. Box 36</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2

Immediate cause (a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

(a)

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

0/none

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work Not While At work

HOW DID INJURY OCCUR?

INTERVAL BETWEEN ONSET AND DEATH

8 hr.

3 yrs.

5 yr

22. I hereby certify that I attended the deceased from Feb 4, 1945, to Feb 5, 1955, that I last saw the deceased

alive on Feb 4, 1955, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/9/55

R. S. Johnson, M. H.

Charles H. Ward - Marion Sta., Md.

Box 235

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 14 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1969
CERTIFICATE OF DEATH

01951

Reg. Dist. No. 265

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Somerset	MARYLAND	STATE Maryland	COUNTY Somerset
CITY (If outside corporate limits, write RURAL OR and give nearest town) 39 Crisfield	LENGTH OF STAY (in this place) 52 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Cove Street		STREET ADDRESS (If rural give location) 1 Cove Street	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Fannie	(Middle) May	(Last) Gerald	(Month) Feb. 17, (Day) 19 (Year) 55
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: June ,1883
9. AGE last birthday: 71 yrs.		10. AGE last birthday: 8 Months 1 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: housewife		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Accomac County, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William S. Scott		14. MOTHER'S MAIDEN NAME: Deliah Crosley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None	
17. INFORMANT & ADDRESS: Mrs. Carrol Jockel, 10 W. Barre, Balto. Md			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 420.1 Coronary Disease (occlusion)			
Antecedent causes (s) Arterio Sclerosis			
DUE TO			
DUE TO			
DUE TO			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: 0		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? X			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2 days before I was called, that I last saw the deceased alive on 19 , and that death resulted from the causes and on the date stated above.			
SIGNATURE Dr. H. Boulbourn		ADDRESS Crisfield Md. Feb. 18/1955	
23. BURIAL, CREMATION, REMOVAL (Specify) BURIED		DATE THEREOF Feb. 19, 1955	
NAME OF CEMETERY OR CREMATORY Sunny Ridge		LOCATION (City, town, or county) (State) Crisfield, Md.	
DATE REC'D BY LOCAL REGISTRAR 2/18/55		REGISTRAR'S SIGNATURE Betty W. Tyler	
24. FUNERAL DIRECTOR Burward Q. Covington		ADDRESS Crisfield, Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 21 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01952
1964 CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH: COUNTY Somerset CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crisfield HOSPITAL OR INSTITUTION OR STREET ADDRESS McCready Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Somerset CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crisfield STREET ADDRESS (If rural give location) 12 Main Street	
3. NAME OF DECEASED: (Type or Print) Josephine Cullen Hall (First) (Middle) (Last)		4. DATE OF DEATH: Feb. 13, 1955 (Month) (Day) (Year)	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: June 21, 1876
9. AGE last birthday: 78 yrs. 7 Months 22 Days 0 Hours 0 Min.		10. USUAL OCCUPATION. Give kind of work done during most of working life even if retired): Housewife	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Jacob B. Cullen		14. MOTHER'S MAIDEN NAME: Melissa Ward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.): No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: None	
17. INFORMANT & ADDRESS: Mrs. Nicholas Riggins, Wilmington, Del.			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332X Immediate cause (a) Cerebral thrombosis - Multiple Antecedent causes (s) (b) attacks since onset in November 2 1/2 mo. Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) Cerebral arteriosclerosis		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
19a. DATE OF OPERATION: Feb. 13, 1955	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Nov. 1954** to **Feb. 1955**, that I last saw the deceased alive on **Feb. 13, 1955**, and that death occurred at **12:00 AM** from the causes and on the date stated above.

SIGNATURE **C. R. Riggins** (Degree or title) **Crisfield, Md.** DATE SIGNED **Feb. 15, 1955**

23. BURIAL, CREMATION, REMOVAL (Specify) **Burial** DATE THEREOF **Feb. 15, 1955** NAME OF CEMETERY OR CREMATORY **Crisfield** LOCATION (City, town, or county) (State) **Crisfield, Md.**

DATE REC'D BY LOCAL REGISTRAR **2/15/55** REGISTRAR'S SIGNATURE **Betty W. Tifer** FUNERAL DIRECTOR **Durward J. Covington, Crisfield, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BOULEVARD V. S.

FEB 1955



1965
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03035

Reg. Dist.

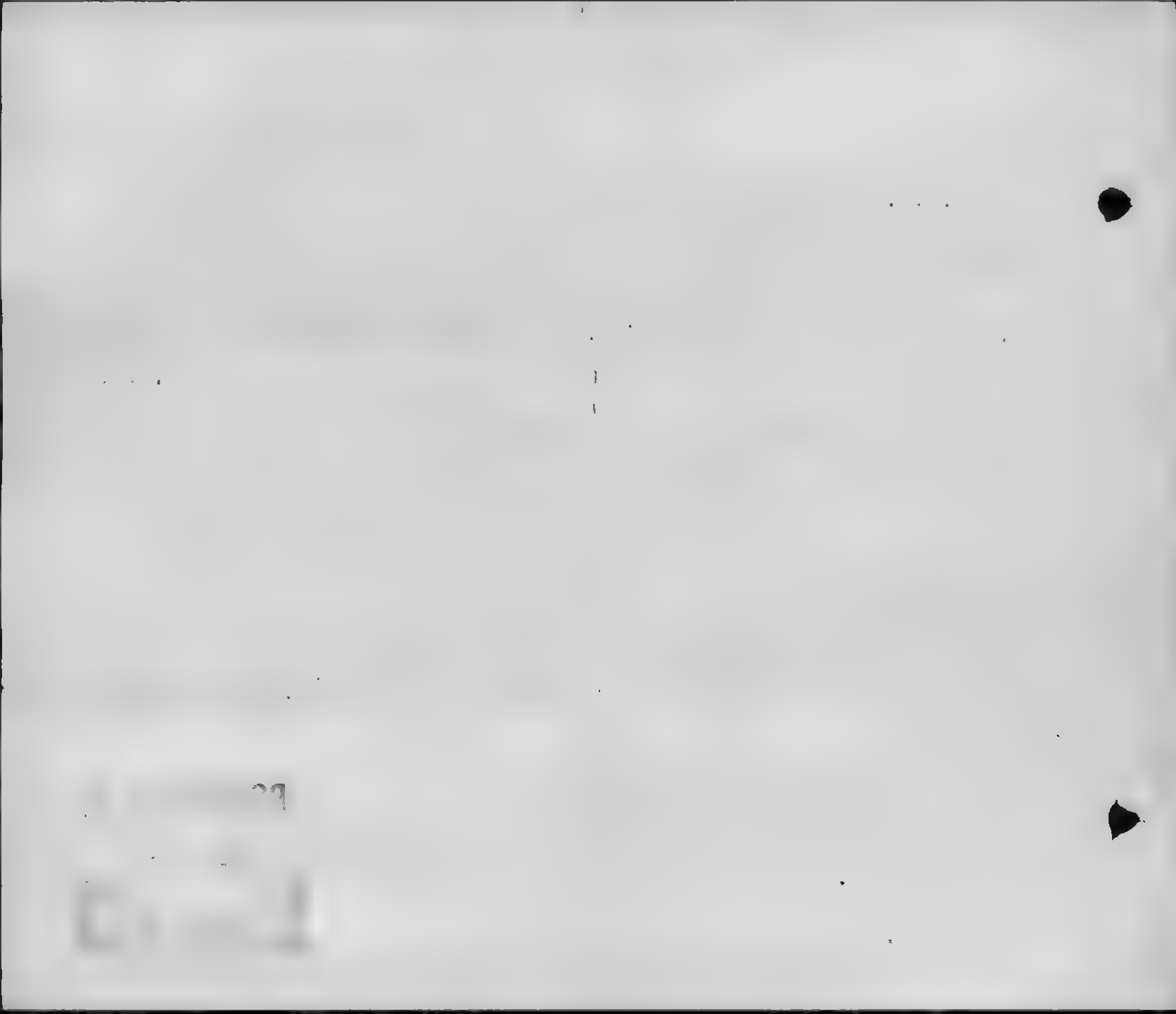
No. 262

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Somerset</u>		MARYLAND	STATE <u>Maryland</u> COUNTY <u>Somerset</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN <u>R.F.D. #1 Box 65</u>			TOWN <u>R.F.D. #1 Box 65</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
<u>Home</u>			<u>Pocomoke City, Maryland</u>		
3. NAME OF DECEASED: (Type or Print)			4. DATE OF DEATH:		
(First) <u>Oscar</u> (Middle) <u>Payton</u> (Last) <u>Handy</u>			(Month) <u>February</u> (Day) <u>15</u> (Year) <u>1955</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:		9. AGE last birthday:
<u>M.</u>	<u>C.</u>	<u>Married</u>	<u>Aug. 18, 1896</u>		<u>58</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>laborer</u>		<u>Farm</u>		<u>Virginia</u>	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Isaac James Handy</u>			<u>Maggie Watson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>No</u>		<u>216-12-1706</u>		<u>Emma Ruter Pocomoke City, Md.</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<p><u>4721</u></p> <p>Immediate cause (a) <u>Acute Coronary Heart Disease</u></p> <p>DUE TO</p> <p>Antecedent cause(s) (b) _____</p> <p>Diseases or conditions, if any, giving rise to the above cause (c) _____</p> <p>stating underlying cause last (c)</p>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</p> <p>SIGNATURE <u>[Signature]</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-15-55</u></p> <p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/></p>					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>2/20/55</u>		<u>Tindley Chapel Cem.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>3/28/55</u>		<u>Mrs. Gracie Rogers</u>		<u>Edgar Wharton - New Church, La.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01953
1970 CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Crisfield		lifetime		TOWN Crisfield		37	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 946 Broad St.				STREET ADDRESS (If rural give location) Broad St.			
3. NAME OF DECEASED: (First) RICHARD (Middle) (Last) HARRIS				4. DATE OF DEATH: (Month) February (Day) 26 (Year) 1955			
5. SEX: Male		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married		8. DATE OF BIRTH: July 26, 1927	
9. AGE last birthday: 27 yrs.		10. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: laborer				10b. KIND OF BUSINESS OR INDUSTRY: Seafood Industry			
13. FATHER'S NAME: Richard Harmon				14. MOTHER'S MAIDEN NAME: Beatrice Harris			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 218-24-2777		17. INFORMANT & ADDRESS: 946 Broad St. Mrs. Rosa Lee Harris—Crisfield, Md.	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
322.1 Immediate cause (a) Myocardial Infarction				Five minutes	
Antecedent causes (s) (b) Chronic Alcoholism				Years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Venous Infection					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 24, 1955, to Feb 26, 1955, that I last saw the deceased alive on Feb 25, 1955, and that death occurred at 1:10 a.m., from the causes and on the date stated above.					
SIGNATURE A. N. Bann M.D.		ADDRESS Crisfield, Md.		DATE SIGNED 3/1/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF Mar. 1, 1955		NAME OF CEMETERY OR CREMATORY Lawsonia Cemetery	
				LOCATION (City, town, or county) Crisfield, Md.	
DATE REC'D BY LOCAL REGISTRAR Mar. 3, 1955		REGISTRAR'S SIGNATURE Betty H. Tyler		24. FUNERAL DIRECTOR Bradshaw & Sons-531 Main St.—Crisfield, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: write the causes of death clearly and legibly.

BUREAU A

MAR 3 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01954
1971 CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY OR (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
39 TOWN Crisfield		lifetime		TOWN Crisfield		29	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 Broadway				Broadway			
3. NAME OF DECEASED:			4. DATE OF DEATH:				
(First) (Middle) (Last)			(Month) (Day) (Year)				
ROSETTA JONES			February 21, 1955				
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED.		8. DATE OF BIRTH:	
female		colored		(Specify) widowed		Sept. 18, 1881	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
housewife		Domestic		Accomack County, Va.		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Littleton Taylor				unknown			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
no		—		Broadway Mrs. Lillian Hall—Crisfield, Md.			

18. MEDICAL CERTIFICATION								Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH									
341X Immediate cause (a) Cerebral Vascular Accident								2 weeks	
Antecedent causes (s) (b) Hemorrhagic Cerebrovascular Disease								Several yrs.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)									
11. OTHER SIGNIFICANT CONDITIONS								6 m	
Conditions contributing to the death but not related to the disease or condition causing death. Inanition. Senile Degeneration									
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY ?	
0								Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?					
22. I hereby certify that I attended the deceased from July 15, 1954, to Feb 22, 1955, that I last saw the deceased alive on Feb 22, 1955, and that death occurred at 6:30 p.m. from the causes and on the date stated above.									
SIGNATURE				ADDRESS				DATE SIGNED	
D. D. Ban				Crisfield, Md.				Feb 24, 1955	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
burial		Feb. 24, 1955		Lawsonia Cemetery		Crisfield, Md.			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE				24. FUNERAL DIRECTOR ADDRESS			
2/24/55		Betty W. Tyler				Bradshaw & Sons—Main St.—Crisfield, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

U. S. DEPARTMENT OF AGRICULTURE

1917

RECEIVED

1966

CERTIFICATE OF DEATH

Reg. Dist. No. 261

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>		LENGTH OF STAY (in this place) <u>87 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <u>Henry</u> (Middle) <u>Upshur</u> (Last) <u>Lankford</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb.</u> <u>24</u> <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>March 25, 1867</u>	
9. AGE last birthday: <u>87 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>24</u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Manokin, Som. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>George Lankford</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Lankford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Clara Young-Marion Sta., Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Condition</u>						about <u>24 hrs.</u>	
ANTECEDENT CAUSE (B) <u>Chronic Myocarditis & Chronic Int. Nephritis</u>						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>at intervals</u> , 19 <u>53</u> , to <u>Feb. 24</u> , 1955, that I last saw the deceased alive on <u>Feb. 24</u> , 1955, and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George C. Boulton MD</u>				ADDRESS <u>Marion Sta. Md.</u>		DATE SIGNED <u>2-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bronch Cemetery</u>		LOCATION (City, town, or county) (State) <u>Marion Sta., Som. Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-25-55</u>		REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>		24. FUNERAL DIRECTOR <u>Charles H. Ward</u>		ADDRESS <u>Marion Sta. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DOUGLAS V. S.

1911

RECEIVED

1972

CERTIFICATE OF DEATH

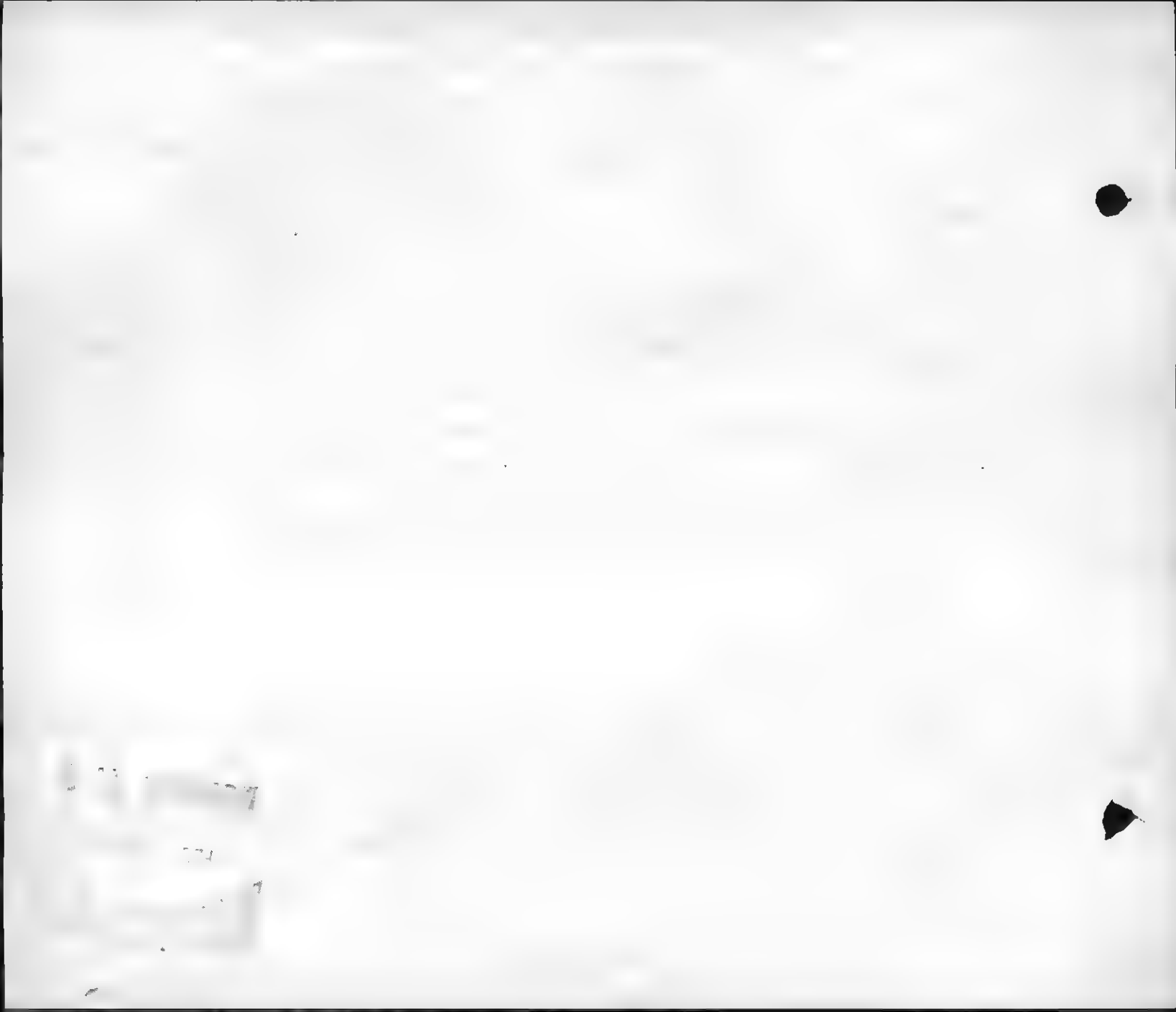
Reg. Dist. No. 265

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Somerset	MARYLAND	STATE Maryland	COUNTY Somerset
CITY (If outside corporate limits, write RURAL OR and give nearest town) 27 TOWN Crisfield	LENGTH OF STAY (in this place) lifetime	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Crisfield	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Turf St.		STREET ADDRESS (If rural give location) Turf St.	
3. NAME OF DECEASED: (First) ROBERT (Middle) (Last) LADDOX		4. DATE OF DEATH: (Month) February (Day) 3 (Year) 19 55	
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: unknown
9. AGE last birthday: about 70 yrs.		10. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: unknown		10b. KIND OF BUSINESS OR INDUSTRY: unknown	
11. BIRTHPLACE (State or foreign country): unknown		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: unknown		14. MOTHER'S MAIDEN NAME: unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) —		16. SOCIAL SECURITY No.: —	
17. INFORMANT & ADDRESS: Deputy Medical Examiner Dr. Wm. H. Coulbourn—Crisfield, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) Coronary Disease			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterio Sclerosis			
(c) Senility			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: no		19b. MAJOR FINDINGS OF OPERATION: none	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY no m.		INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR? None			
22. I hereby certify that I attended the deceased from <u>He was found dead before</u> and that death occurred at <u>Crisfield</u> , from the causes and on the date stated above. Signature <u>Wm. H. Coulbourn M.D.</u> ADDRESS <u>Crisfield, Md.</u> DATE SIGNED <u>2/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>Feb. 9, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Lawsonia Cemetery</u>		LOCATION (City, town, or county) (State) <u>Crisfield, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/8/55</u>		REGISTRAR'S SIGNATURE <u>Betty W. Tyler</u>	
24. FUNERAL DIRECTOR <u>Bradshaw & Sons—Crisfield, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1967

CERTIFICATE OF DEATH

01957

Reg. Dist. No. 265

1. PLACE OF DEATH: COUNTY Somerset CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Crisfield LENGTH OF STAY (in this place) 78 yrs HOSPITAL OR INSTITUTION OR STREET ADDRESS Sackertown Road		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Somerset CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Crisfield STREET ADDRESS (If rural give location) Sackertown Road	
3. NAME OF DECEASED: (First) William (Middle) H. (Last) Nelson		4. DATE OF DEATH: (Month) Feb. (Day) 23 (Year) 1955 XXX	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Oct. 15, 1876
9. AGE last birthday: 78 yrs. 4 Months 8 Days		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Waterman	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY: USA	
13. FATHER'S NAME: George L. Nelson		14. MOTHER'S MAIDEN NAME: Elizabeth Sterling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: AN-220-09-1294	
17. INFORMANT & ADDRESS: Susan Nelson, Crisfield, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>197X Immediate cause (a) Transition</p> <p>Antecedent causes (s) (b) Carcinoma of the Prostate with Metastasis</p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)</p>			
Interval Between Onset And Death 7 years.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 8 , 1955, to Feb 23 , 1955, that I last saw the deceased alive on Feb 23 , 1955, and that death occurred at 6.30 P.M. , from the causes and on the date stated above.			
SIGNATURE G. N. Baw		DATE SIGNED Feb 24, 1955	
23. BURIAL, CREMATION, (Specify) burial		DATE THEREOF Feb. 25, 1955	NAME OF CEMETERY OR CREMATORY Asbury em.
LOCATION (City, town, or county) Crisfield, Md.		(State) Md.	
DATE REC'D BY LOCAL REGISTRAR 2/25/55		REGISTRAR'S SIGNATURE Betty W. Tyler	
24. FUNERAL DIRECTOR Durward G. Covington		ADDRESS Crisfield, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED V. S.

183

RECEIVED

MARYLAND 1968

01958
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 360

1. PLACE OF DEATH COUNTY SOMERSET		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY SOMERSET	
CITY (If outside corporate limits, write RURAL and OR give nearest town) PRINCESS ANNE		CITY (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED (Type or Print) LEAH		4. DATE OF DEATH 2/18/55	
5. SEX FEMALE		6. COLOR OR RACE COLORED	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED		8. DATE OF BIRTH 11/12/1872	
9. AGE last birthday 82		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY HOUSE	
11. BIRTHPLACE (State or foreign country) SOMERSET COUNTY MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM JOHN DENNIS		14. MOTHER'S MAIDEN NAME JANE WATERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS CONSTON ROBERTS			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) 422.2 Immediate cause		6 days	
(b) Chronic myocarditis		18 mths	
(c) Antecedent cause(s)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 20, 1953 , to Feb 18, 1955 , that I last saw the deceased alive on Feb 18, 1955 , and that death occurred at 6:00 p.m. , from the causes and on the date stated above.			
SIGNATURE Eddas G. Mathews M.D.		DATE SIGNED 2-21-55	
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		NAME OF CEMETERY OR CREMATORY JOHN WESLEY	
DATE 2/22/55		LOCATION (City, town, or county) (State) PRINCESS ANNE, MD.	
DATE REC'D BY LOCAL REG. 2/22/55		REGISTRAR'S SIGNATURE R. S. Johnson M.D.	
24. FUNERAL DIRECTOR Wallace H. Jones		ADDRESS Princess Anne	

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 28 1955

BUREAU V. S.

01959

MARYLAND 1973

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH COUNTY <u>Somerset</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Crisfield</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>114 S. 4th St.</u>		STREET ADDRESS (If rural, give location) <u>114 S. 4th Street</u>	
3. NAME OF DECEASED (First) <u>Josanna</u> (Middle) <u>Thomas</u> (Last) <u>Thomas</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>23</u> (Year) <u>1955</u>	
5. SEX <u>Fe.</u> COLOR OR RACE <u>Col.</u>		6. DATE OF BIRTH <u>Mar. 3, 1888</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>widowed</u>		8. AGE last birthday <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nurse</u>		11. BIRTHPLACE (State or foreign country) <u>Westover</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Henry Milbourne</u>		14. MOTHER'S MAIDEN NAME <u>Josanna Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Gladys Milbourne, 114 S. 4th Street</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>260X Cerebral Thrombosis</u>			<u>7 yrs</u>
(b) Antecedent cause(s) <u>Cerebral arteriosclerosis</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Diabetes Mellitus</u>			<u>10 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hyper-trophic Arteriosclerosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Feb. 23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb. 23</u> , 19 <u>55</u> , and that death occurred at <u>1:30 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. M. Peyton</u>		DATE SIGNED <u>Feb. 27, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		LOCATION (City, town, or county) (State) <u>Crisfield, Somerset Co., Md.</u>	
DATE REC'D BY LOCAL REG. <u>2/27/55</u>		24. FUNERAL DIRECTOR ADDRESS <u>Charles H. Ward, Marion St., Md.</u>	
REGISTRAR'S SIGNATURE <u>Betty W. Tifer</u>			

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 7 1955

RECEIVED